GASTROENTEROLOGY ENROLLMENT FORM

HILL COUNTRY PHARMACY

Fax to: 844.295.5518

DATE: _____
DATE NEEDED: _____

SHIP TO: ☐ PATIENT ☐ OFFICE

PHARMACY LOCATION
11233 SHADOW CREEK PARKWAY, SUITE 123A
PEARLAND, TEXAS 77584
1.844.295.5516

PATIENT INFO

NAME _____ E-MAIL _____ DOB _____ ☐ MALE ☐ FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME TELEPHONE _____ MOBILE PHONE _____ SS# _____

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

CLINICAL INFORMATION

Diagnosis Codes

Date of Diagnosis: _____

☐ K50.00_____ Crohn's Disease

☐ K51.80_____ Ulcerative Colitis

☐ Other: _____

Treatment History

☐ New to this medicine ☐ Continued Treatment

If continuing treatment, has patient's condition improved or stabilized? ☐ Yes ☐ No

Patient Weight:_____kg / lb

Allergies? ☐ Latex ☐ Other: _____

Concomitant Medications:_____

Crohn's/UC Severity: ☐ Moderate ☐ Severe ☐ Mild

Presence of Enterocutaneous/Rectovaginal Fistulas? ☐ Yes ☐ No

Has patient been diagnosed with Heart Failure? ☐ Yes ☐ No

Has patient been diagnosed with Lymphoma? ☐ Yes ☐ No

Does patient have serious/active infection? ☐ Yes ☐ No

TB/PPD Test Results? ☐ No ☐ Yes ☐ Result? _____

Is patient at risk for Hepatitis B infection? ☐ Yes ☐ No - If Yes, has Hepatitis B been ruled out or treatment started? ☐ Yes ☐ No

☐ Other: _____

Prior Failed Medication(s)

Medication _____
Length of Treatment _____ **to** _____
Reason for Discontinuing _____

Medication _____
Length of Treatment _____ **to** _____
Reason for Discontinuing _____

Medication _____
Length of Treatment _____ **to** _____
Reason for Discontinuing _____

Manufacturer's Support: Is patient enrolled in the product manufacturer's sponsored support program? *(example: myHUMIRA, AccessOne)* ☐ Yes ☐ No

PRESCRIPTION INFORMATION

☐ Cimzia® *(Crohn's)*

☐ **Starter Dose:**
- ☐ Starter Kit (200mg Pre-filled Syringe)
- ☐ Vial (200mg/ml) & supplies

☐ **Starter Directions:**
- ☐ Inject 400mg SC at weeks 0, 2, and 4
- ☐ Other: _____

QTY: ☐ 1 pre-fill syr KIT (6x200mg syr)
☐ 6 vials ☐ _____ | **Refills**_____

☐ **Maintenance Dose:**
- ☐ Pre-filled Syringe (200mg/ml)
- ☐ Vial (200mg/ml) & supplies

☐ **Maintenance Directions:**
- ☐ Inject 400mg SC every 4 weeks
- ☐ Other: _____

QTY: ☐ 2 pre-filled syr ☐ 4 vials
☐ _____ | **Refills**_____

☐ Entyvio® *(Crohn's/UC)*

☐ 300mg/20ml Vial

☐ **Initial Directions:**
- ☐ Administer 300mg via IV infusion at Weeks 0, 2, and 6, then maintenance dosing.
- ☐ Other: _____

☐ **Maintenance Directions:**
- ☐ Administer 300mg via IV infusion every 8 weeks.
- ☐ Other: _____

QTY: ☐ _____vials | **Refills**_____

☐ Humira® *(Crohn's - UC)*

☐ Crohn's/Ulcerative Colitis Starter Kit

☐ **Induction Dose:**
- ☐ Inject 160mg (4 pens) SC on day 1 , then 80mg Kit(2 pens) on day 15, then maintenance dosing
- ☐ Other: _____

QTY: ☐ 1 KIT | **Refills**_____

☐ **Maintenance Dose:**
- ☐ Pen (40mg/0.8ml)
- ☐ 40mg/0.8ml Prefilled Syringe (PFS)

☐ **Maintenance Directions:**
- ☐ Pen: Inject 40mg (one pen) SC every other week
- ☐ PFS: Inject 40mg (one syringe) SC every other week
- ☐ Other: _____

QTY: ☐ 2 ☐ _____ | **Refills**_____

☐ Remicade® *(Crohn's/UC)*

☐ Vial (100mg/20ml)

☐ **Initial Dosing:**
- ☐ Administer 5 mg/kg (Dose = _____mg) at 0, 2, & 6 weeks, then q 8 weeks

☐ **Maintenance Dosing:**
- ☐ Administer _____mg/kg every _____ weeks
- ☐ Other: _____

QTY: ☐ ____Vials | **Refills**_____

☐ Simponi® *(UC)*

☐ SmartJect Autoinjector (100mg/ml)
☐ Prefilled Syringe (100mg/ml)

☐ **Initial Dosing:**
- ☐ Inject 200mg(2 autoinj/syringes) SC on week 0, then 100mg (1 autoinj/syringe) on week 2, then 100mg (1 autoinj/syringe) every 4 weeks

☐ **Maintenance Dosing:**
- ☐ Inject 100mg (1 pen/syringe) SC every 4 weeks

QTY: ☐ 3 autoinj/syr on first dispense, and 1 for refills
☐ 1 autoinj/syr
☐ _____ | **Refills**_____

☐ Other

Drug Name: _____

☐ Strength: _____
☐ Directions: _____

QTY: ☐ _____ | **Refills**_____

Supportive Care

☐ Methotrexate

☐ 2.5 mg tablets ☐ 25 mg/ml vials

☐ **Dosing:**
- ☐ _____

QTY: ☐ _____ | **Refills**_____

☐ Other

Drug Name: _____
☐ Strength: _____
☐ Directions: _____

QTY: ☐ _____ | **Refills**_____

INJECTION TRAINING ☐ Patient has received injection training ☐ Physician Office to provide injection training ☐ Pharmacy to provide injection training

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person: _____

Telephone: _____ Fax: _____ Email: _____

Office Address: _____ City: _____ State: _____ Zip: _____

NPI # : _____ DEA # : _____ Tax ID # : _____ Medicaid Provider # : _____

_____ _____ *

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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